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Nursing Homes: An Analysis of the Types of Patients Accommodated and the Nursing Services Provided

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INTRODUCTION

The Bureau of Hospitals of the California State Department of Public Health in the administration of the hospital licensing program has felt a need for more information regarding the services which are available in the nursing homes throughout the State as well as the types of patients which are being cared for in such facilities.

Much is being said about chronic care accommodations and the inadequacies of the present facilities. Hospitals are said to be overcrowded because of the increase of chronic diseases brought about by the extended life span of today's population. It is well known that many individuals cannot be cared for in their homes and are finding their way into "nursing homes." The many inquiries coming to the Bureau of Hospitals are evidence that need exists in many communities for this type of facility.

A study already completed by the State Department of Public Health* revealed that almost 9,000 beds are licensed in the nursing homes of California. These beds are found in 450 nursing homes located throughout the State. That study further revealed that while most of these facilities are relatively safe and are capable of providing adequate facilities for patient care, there are many deficiencies which do exist and which if corrected would result in improved patient care more in harmony with what is advocated in the care of the chronically ill.

The following study has as its main objectives the determination of the types of patients being accom-

modated, the utilization of beds in nursing homes as determined by occupancy, and the nursing services which are being rendered in these nursing homes.

This information was secured from results of a questionnaire completed by field personnel of the Bureau of Hospitals at the time of their regular visits to the nursing homes. A three-month period was used to secure this material and the questionnaire was filled out on all nursing homes visited by the field staff. It can be assumed that the sampling secured by this method is fairly typical of all facilities throughout the State.

One hundred sixty-eight nursing homes, representing a total of 3,652 licensed beds, or 42 percent of all nursing home beds in the State, are included in the study.

Two thousand eight hundred sixty-five persons were housed as patients in these homes at the time the questionnaire was completed.

CAPACITY

The capacity of the nursing homes included in this sampling ranged from 3 beds to 88 beds. The following table shows the range of capacity as well as the number and percentage of nursing homes in each range:

Capacity	Number of nursing homes	Percentage of nursing homes
2-10 beds	51	30%
11-25 beds	52	31%
26-50 beds	58	35%
51+ beds	7	4%

For purposes of this study, the above classification of range of capacity has been retained. It has been

* See "Nursing, Convalescent, and Rest Homes in California," Bernice Hotchkiss, R.N., *California's Health*, March 15, 1952.

expressed by some authorities that the size of the facility has a direct bearing on the type of care which is provided as well as the quality of service which is available. Apparent differences in this report will be pointed out.

The range of capacity in the sampling is not typical of all facilities licensed by the State Department of Public Health. Actually only 26 percent of the total number of nursing homes have more than 25 beds; however, 39 percent of the homes in the sampling have bed capacities greater than 25 beds. Also, 43 percent of the total facilities have capacities of fewer than 11 beds, but the study included only 30 percent in this range. While this discrepancy does not alter the general conclusions in this study, it should be kept in mind where distinctive differences appear between the large and small facilities.

OCCUPANCY

Average occupancy of the 168 nursing homes included in the study was 83 percent, with a median of 86 percent. Of the total number of facilities in this study, 99 were operating with occupancies greater than 75 percent. Only 12 were operating with occupancies less than 50 percent.

The following breakdown serves to show that the size of the facility has a direct relation to its occupancy, the small nursing home tending to operate at a higher occupancy than the large one.

The small nursing homes of 2- to 10-bed capacity were operating with an average of 92 percent occupancy. Of the 51 homes in this category, 22 facilities, or 43 percent, were operating at a 100 percent occupancy.

In the 11- to 25-bed class, the facilities averaged 87 percent occupancy. Sixteen nursing homes, or 36 percent of the 52 nursing homes, were operating at full capacity.

In the nursing homes with capacity beyond 26 beds, the occupancy was 73 percent, with only seven of the 65 facilities operating at 100 percent occupancy.

These high occupancy figures substantiate the idea that a great need exists for this type of hospital facility. These nursing homes are meeting a definite need and are providing a type of care which apparently is not available or possible in the home or the general hospital. On the basis of this sampling, it can be assumed that about 7,500 persons are being cared for by this category of hospitals in the State.

The higher rate of occupancy in small nursing homes in comparison with the larger is significant, and clearly illustrates the existing demand for this type of facility. There are probably many reasons why these homes were almost fully occupied. It should be remembered that almost every nursing home, whether

large or small, is attempting to operate for profit. The small nursing home must meet the same minimum standards for state licensure as the large one. This usually entails a rather large expenditure of money in order to comply with physical requirements. As a result, in order to realize a profit, the small nursing home must operate with all beds occupied. In these small facilities, the operating cost is substantially the same whether all beds are occupied or not. Consequently, greater conscious efforts are probably made by the operator to keep the beds full. There is also the contention that the chronically ill patient in the small nursing home can enjoy more of a home environment than is possible in the larger, institutional type of facility.

TYPE OF PATIENTS

In an effort to determine the amount and type of personnel necessary for the care of these patients, some information on the physical status of the patient was obtained. While it is not always true that the bed patient requires more care than the ambulatory patient, it does give some idea as to the attention and care which is usually required. Size of the facility apparently does not affect the types of patients which are accepted for care so the breakdown by size will not be considered in this section of the report.

Of the 2,865 patients in the 168 nursing homes, 5 percent required no specific care. The services which were provided for them consisted of board, room, and minimum supervision. (These patients are ambulatory, are able to carry on their ordinary routine without assistance and need only the protection of having a responsible person on hand if necessary.) It would appear that this small percentage of persons has been financially able to select this type of facility for every day living, and these persons probably experience some feeling of security, knowing that residence can be retained in case of illness.

Thirty-six percent, or 917 patients, were ambulatory but required some assistance and attention. Such assistance may have consisted of help in such daily tasks as bathing, walking or dressing, or it may have meant providing therapeutic diets, administering medications, dressings or treatments. Such attention and care may be necessitated by physical infirmity and senility, by chronic disease, or by convalescence from acute illness. While this type of patient usually does not require as much care as bed patients, some patients in this category do require skilled personnel for medical and nursing care and supervision.

While 59 percent of the patients included in the study were classified as bed patients, 23 percent were declared to be absolute bed patients while the remaining 36 percent could get out of bed or be assisted

out of bed at least every day. The patients designated as strict bed patients were unable to be out of bed because of physicians' orders, because of disease or physical infirmity, or because of lack of encouragement and assistance by the staff in the nursing home. Bed patients, whether absolute or not, require extensive and skillful nursing care. Even though a patient is allowed out of bed for a few minutes or a few hours every day, skillful handling and close supervision are usually required. The procedure of helping a patient get out of bed and into a chair often requires as much skillful handling and consumes more time than if the patient were left in bed. In fact, some of the homes reporting a high percentage of strictly bed patients, could probably reduce this percentage if efforts were made to get patients out of bed. Lack of personnel and lack of knowledge of modern care of the chronically ill is probably responsible for this high percentage.

It was noted that 22 nursing homes had no ambulatory patients at all, but listed all their patients as bed patients with some of those bed patients being able to be up in a chair every day.

Thirty-two nursing homes declared no absolute bed patients. Operators claimed that all their patients were either ambulatory or could be out of bed with or without assistance.

Fourteen facilities declared all patients to be ambulatory. However, all 14 had patients who required some type of medical or nursing care.

NURSING PROCEDURES

The study shows that 44 percent of all patients are able to take tub baths, the remainder requiring bed baths. This means that while more than half are given bed baths, some of those being given tub baths are actually bed patients and require attention and skill in the procedure. It is well recognized that in every hospital much time is consumed in the task of bathing patients. From the number of bed baths reported, it was apparent that one-third of the nursing homes were giving their patients bed baths daily. The questionnaire was not intended to get information for the purpose of evaluating adequacy of nursing care, but instead it attempted to get some data which would determine the amount of time consumed in these tasks.

Twenty percent of the total number of patients were on special therapeutic diets. Special point was made not to include in this percentage diets which were special only because of the patient's inability to chew, swallow, etc. While the special diets in a nursing home are usually relatively simple, a basic knowledge of nutrition and nutritional needs of the individual patient are required in order that physicians' orders be complied with and adequate diets be provided.

There is probably need for much to be done in the field of nutrition for patients in these homes. It is felt that many operators either do not realize what the basic nutritional needs of the aged are, or are more concerned with providing a cheap diet than with having the food served meet nutritional needs.

Thirty percent of the patients required assistance with eating. In some cases this meant actually feeding the patient because he was too ill, needed encouragement, or was not physically able to feed himself. In other cases, it meant only assisting the patient by cutting meat, buttering bread, etc., so that the patient would be able to feed himself.

Two percent of the patients had pressure sores. The patients with pressure sores were centralized in 46 nursing homes. One home reported that it had four patients with pressure sores, totaling 15 percent of its patients. Others for the most part reported single patients in their facilities with this affliction.

An average of 31 percent of all patients in nursing homes were declared to be incontinent, having no control of urine or feces. This is rather a startling figure and presents a nursing problem of great magnitude. It is well known that incontinence is a common accompaniment of old age and likely to occur among such persons. With expert nursing care and more adequate staffing, it is felt that many of these oldsters would not be incontinent and this percentage might be reduced.

About 68 percent of the patients were getting some type of medication. The most common mode of administration was by mouth, although hypodermic, intramuscular and intravenous methods were employed in many facilities. Only five nursing homes reported that no patients were receiving medication. Fifty-one of the 168 facilities reported that they had given no hypodermics during the preceding week.

In five of the 168 homes, no tasks which can be considered nursing procedures were being performed; in 18, the only procedure was bed baths; in 15, only bed baths and medications; and in 20, bed baths, medications, and enemas comprised the total skilled nursing procedures.

Except for bed baths and medications, the most common nursing procedure being performed in nursing homes was the administration of enemas. Only 37 homes reported that no enemas had been given during the preceding week. The frequency of this procedure is necessitated by the type of elderly patient likely to be found in the nursing home.

Less than half of the nursing homes had been required to apply surgical dressings during the preceding week. Even in these, the questionnaire revealed that usually only one patient in each home was getting

regular dressings. It can be assumed that this procedure is not often employed.

Irrigations (eye, throat, bladder) had been performed in 38 nursing homes. This seems unusually low when it is realized that many elderly male patients frequently have in-dwelling catheters which necessitate bladder irrigations.

Intravenous injections, usually medications, had been given in 19 nursing homes during the preceding week.

The use of the heat lamp for treatment of various ailments was common in 29 nursing homes.

Massage, oxygen therapy, diathermy, physiotherapy, inhalation therapy, and application of compresses were other procedures which were listed as less frequently employed in the nursing homes included in the questionnaire.

CONCLUSION

Our nursing homes, in addition to providing protection and custodial care are providing to some extent a certain type of medical and nursing care. The amount of care varies, in that some nursing homes are staffed and equipped to accept patients requiring very extensive and skilled care while others are not able to do so. The need for this type of facility is evidenced by the high occupancy of many of these nursing homes.

As a result of the information gathered for this study, the following nursing procedures appear necessary to provide the medical and nursing services which should be available in today's nursing homes. It is quite possible and even desirable that other more complex procedures be performed in certain cases where the staff and equipment are available. However, the following procedures appear to be necessary to provide the necessary minimum services.

1. Personal care of patient
 - a. Making patient comfortable
 - b. Knowledge of supportive measures to be applied for patient's comfort and happiness
 - c. Giving bed baths
 - d. Assisting with tub baths
 - e. Assisting patients in and out of bed
 - f. Care of incontinent patients
 - g. Skin care, and nail care
 - (1) Prevention of pressure sores
 - (2) Treatment of pressure sores
 - h. Hair shampoos (in and out of bed)
 - i. Care after death
2. Medication
 - a. Technics of administration
 - (1) Hypodermic
 - (2) Intramuscular
 - (3) Oral
 - (4) Installation of eye and nose drops
 - b. Knowledge
 - (1) Usual dosage
 - (2) Signs of overdosage
 - (3) Methods of administration
 - (4) Effect and reaction
3. Nutrition
 - a. Knowledge of nutritional needs
 - b. Ability to prepare special diets
 - c. Feeding patients
4. Charting—patients' records
5. Recognition, observation and interpretation of symptoms
6. Temperature, pulse, respiration and blood pressure
 - a. Technics
 - b. Interpretation
 - c. Recording
7. Aseptic technic
 - a. Knowledge
 - b. Methods of applying sterile dressings
8. Compresses
 - a. Technics
 - b. Indications, contra-indications
 - c. Applications of ice bags, hot water bottles, etc.
9. Catheterizations
 - a. Technics
 - b. Contra-indications
10. Douches
11. Enemas
 - a. Types
 - b. Technics
 - c. Contra-indications
12. Application of heat lamp

San Diego Begins Fluoridation—Fifth City in State

San Diego began fluoridation of its public water supply on November 10th. On that date fluorides were being added at the main source of supply, the Alvarado station, which serves 60 percent of the city's population. Before the end of November the city expected to have completed the installation of equipment at two smaller stations, after which 100 percent of the population will be receiving fluoridated water.

San Diego is the fifth city in California to fluoridate its public water supply. It was preceded in 1951 by Visto (Solano County) and in 1952 by Morgan Hill (Santa Clara County), Antioch (Contra Costa County), and San Francisco. With the addition of San Diego, these cities comprise a population of approximately 1,225,000 persons.

The U. S. Public Health Service has announced that as of October 15, 1952, fluorides were being added to the water supplies of 435 U. S. communities, serving a population in excess of 9,000,000.

Northern California P. H. Association to Meet in Sacramento

The fall meeting of the Northern California Public Health Association will be held in Sacramento on Friday, December 12, 1952. The meeting place has not yet been decided upon, but announcements will soon be sent to all members of the association and to all local health departments.

The subject of the meeting will be "Alcoholism." Afternoon and evening sessions are planned beginning at 3 p.m. There will be a panel discussion of public health aspects of the problem in the afternoon. The dinner speaker will be Gregory Bateson, well-known cultural anthropologist, who is ethnologist with the Veterans Administration Hospital at Palo Alto. He will discuss cultural and social factors in alcoholism.

The Northern California Public Health Association is an affiliate of the American Public Health Association and members of APHA who live in Northern California automatically belong. However, any Northern Californian who is interested in public health may become an associate member of the Northern California Public Health Association by paying dues of a dollar a year. At the spring meeting held in Palo Alto the following officers were elected for the year 1952-53:

President—Rena Haig, Chief, Bureau of Public Health Nursing, State Department of Public Health.

President-elect—Ellis Sox, M.D., Health Officer, San Francisco Department of Health.

Vice President—Marian Dingley, Laboratories, Richmond Health Department.

Secretary—Doris L. Robinson, Director of Nursing, San Francisco Department of Health.

Treasurer—Mrs. Fern E. French, Lecturer in Public Health, School of Public Health, University of California.

Representative on Governing Council APHA—Levitte Mendel, Director of Health Education, San Jose Health Department.

Representative on Regional Board Western Branch APHA—Thomas McGowen, Public Health Engineer, San Jose Health Department.

Public Health Positions Open

Humboldt County

Public Health Nurse—One position to be filled. Beginning salary is \$332. Applicants must meet California requirements for a public health nursing certificate. For further information write to the Director of Public Health Nursing, Humboldt-Del Norte County Department of Public Health, 805 Sixth Street, Eureka, California.

Kings County

The following positions are open in the Kings County Health Department:

Director of Public Health Nursing
Bacteriologist in Charge of Laboratory
Staff Sanitarian

Salary determination for each of these positions depends on the qualifications of the applicants. For information write to Mr. Franklin Scott, Kings County Health Department, 319 Lacey Boulevard, Hanford, California.

Health Officer Vacancies

Kings County

Kings County announces a vacancy for *Health Officer*. The salary range is \$677 to \$811, but especially well qualified applicants will be considered for a beginning salary higher than the minimum. For further details interested public health physicians should write to Robert D. Williams, Kings County Board of Supervisors, Court House, Hanford, California.

Merced County

A vacancy in the position of *Health Officer* of Merced County has just been announced. Applications from qualified experienced public health physicians will be received by the Merced County Board of Supervisors, and should be addressed in care of Supervisor Glenn M. Fountain, Courthouse, Merced, California. Salary determination is subject to the qualifications of the applicant.

Diarrheal Outbreak Investigated in Orange County

Since early October the Orange County Health Department has reported an unusual number of cases of diarrheal disease. Twenty-two cases were included in the first report, and later 14 more were reported. Investigation by Orange County and State Department of Public Health staff revealed that the 36 cases occurred in 10 families living in a privately owned postwar housing project in which there are about 500 people of low economic status. About half of the cases were in young children from one to four years old. There have been no deaths, but all the child victims required hospitalization and were treated at the County Hospital.

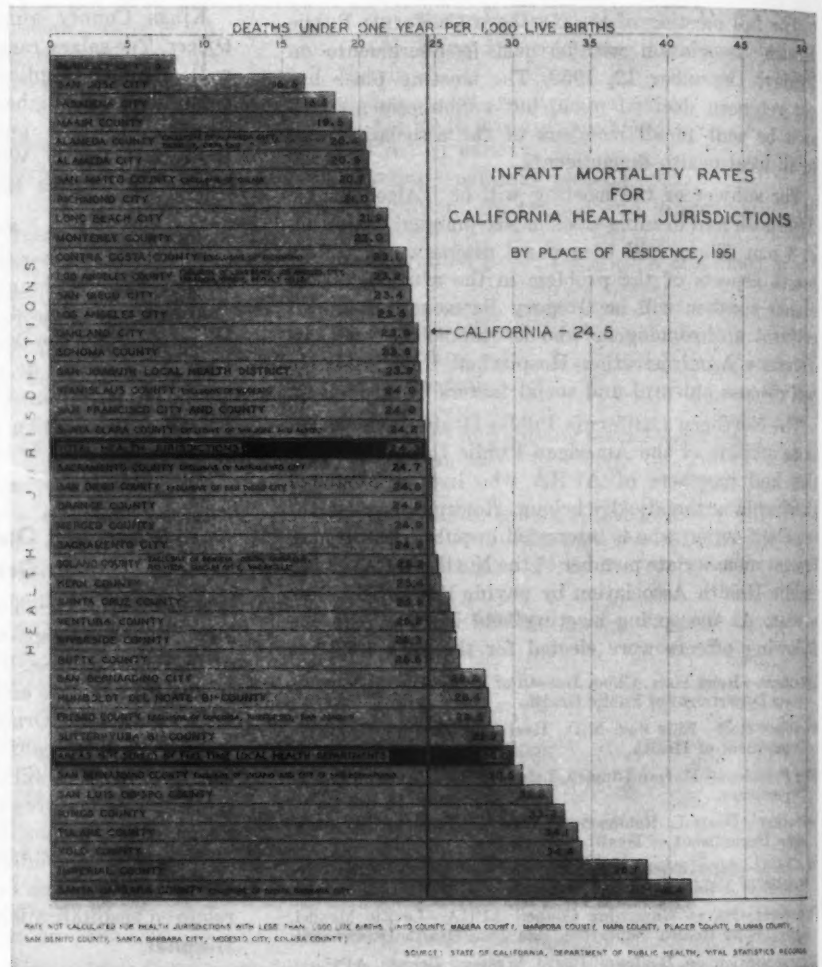
Laboratory stool examinations have been completed for 11 of the patients and the organism causing the diarrhea has been identified as *Shigella flexner* (2-A). Continuing epidemiological investigation has not yet determined the original source of infection. No large numbers of new tenants have recently come to the project, nor is there any evidence to support the theory that the disease was endemic in that area previous to this epidemic. The usual modes of transmission, such as by food, milk, water, or flies, have been ruled out as primary sources. The transmission seems to have been from person to person in certain families.

The Orange County Health Department has instituted as control measures the improvement of the general sanitation in the housing area and a program of education of the people living there to help them understand the cause of the disease and its means of transmission.

INFANT MORTALITY IN CALIFORNIA

Since public health authorities often use infant mortality rates as an index of the effectiveness of the general public health program in a given area, the accompanying graph and table will be of special interest. The graph at the right shows the rank order of 1951 infant mortality rates of 42 areas served by full-time local health departments in California. Those health jurisdictions with 1,000 or more live births are presented individually, while a rate for all health jurisdictions is shown in the shaded bar in the middle of the graph. The lower shaded bar represents the rate for all areas not served by full-time local health departments.

The infant mortality rates for the State as a whole and for many of the areas are lower in 1951 than in 1950. However, it should be borne in mind that in areas where the number of live births is small, an increase or a decrease in the number of infant deaths can make a large change in the rate. A comparison of the 1951 rates with the five-year average rates for the same health jurisdiction will give a more complete picture, since the yearly fluctuations due to small numbers are reduced. The five-year aver-



age rates for the same jurisdictions shown in the graph are listed in the table on page 79.

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FLUORIDATION: A CORRECTED LISTING

Some inaccuracies and misinterpretations, due to incomplete and erroneous information received from several sources, appeared in the listing "Fluoridation in California as of September 1, 1952," in the September 15, 1952 issue of *California's Health*. Primary sources have since been checked and the following is a corrected summary of available information as of November 14th.

Fluoridation Now in Effect

Rio Vista, October, 1951	San Francisco, August, 1952
Morgan Hill, April, 1952	San Diego, November, 1952
Antioch, August, 1952	

Alameda¹
Berkeley¹
Colusa
Oakland¹

* Approved by City Council

Placerville
Pleasanton
Richmond¹

San Leandro¹
Sunnyvale
Woodlake

* Approved by Popular Vote

Belmont
Hayward

Healdsburg
Martinez²

Disapproved by Popular Vote

Carmel
Cloverdale
Lodi
Monterey

Oakdale
Pacific Grove
San Bruno
San Carlos

Santa Cruz
Santa Maria
Santa Rosa

¹ Does not necessarily mean that this is the final step in approving fluoridation.
² Approval by city council constitutes an official recommendation to East Bay Municipal Utilities District.
³ Voters recommended fluoridation to city council which later disapproved fluoridation.

Infant Mortality

(Continued from page 78)

FIVE-YEAR AVERAGE INFANT MORTALITY RATES BY RANK ORDER HEALTH JURISDICTIONS OF CALIFORNIA WITH AN AVERAGE OF 1,000 OR MORE LIVE BIRTHS PER YEAR 1946-1950

(By Place of Residence)

Health jurisdiction	Average rate	Rank order
Full-time Local Health Departments:		
San Mateo County (exclusive of Colma) ¹ -----	18.8	1
Berkeley City-----	20.0	2
Marin County-----	21.8	3
Pasadena City-----	23.1	4
Long Beach City-----	24.6	5
Los Angeles County (exclusive of the cities of Pasadena, Long Beach, Los Angeles, Beverly Hills and Vernon) ² -----	24.7	6
San Francisco City and County-----	24.7	6
San Jose City-----	25.1	7
Oakland City-----	25.5	8
Alameda City-----	25.9	9
Richmond City-----	26.3	10
Contra Costa County (exclusive of Richmond)-----	26.8	11
Alameda County (exclusive of Alameda, Berkeley and Oakland)-----	27.0	12
San Diego City-----	27.1	13
Yolo County-----	27.1	13
Los Angeles City-----	27.3	14
Sonoma County-----	27.3	14
San Luis Obispo County-----	27.8	15
San Diego County (exclusive of San Diego City)-----	28.0	16
Orange County-----	28.2	17
Sacramento City-----	28.4	18
Santa Clara County (exclusive of San Jose and Alviso) ³ -----	29.2	19
Humboldt-Del Norte Bi-County-----	29.4	20
Santa Barbara County (exclusive of Santa Barbara City)-----	29.5	21
Monterey County-----	29.7	22
Sacramento County (exclusive of Sacramento City)-----	30.1	23
Solano County (includes only Vallejo and Solano rural) ⁴ -----	30.7	24
Stanislaus County (exclusive of Modesto)-----	30.9	25
Butte County-----	31.5	26
Merced County-----	31.8	27
San Bernardino City-----	31.8	27
San Joaquin Local Health District-----	32.3	28
Ventura County-----	32.6	29
Sutter-Yuba Bi-County-----	33.7	30
Kern County-----	34.0	31
Santa Cruz County-----	34.6	32
San Bernardino County (exclusive of the cities of San Bernardino and Ontario)-----	35.2	33
Fresno County (exclusive of the cities of Coalinga, Kingsburg and San Joaquin) ⁴ -----	35.7	34
Riverside County-----	36.1	35
Tulare County-----	41.6	36
Kings County-----	43.5	37
Imperial County-----	50.9	38
Total, health jurisdictions served by full-time local health departments-----	28.0	
Areas not served by full-time local health departments ⁵ -----	29.4	
California total-----	28.1	

¹Total county in 1946 and 1947.

²Includes Vernon City in 1946.

³Includes Alviso City in 1946.

⁴Total county in 1946.

⁵Includes 17 rural counties and 14 cities and towns.

SOURCE: State of California, Department of Public Health, birth and death records.

Health Department Consolidation Voted in San Diego

On November 4, 1952, the voters of San Diego City and County voted two to one to consolidate the city and county health departments. The proposal to consolidate the two departments had been supported by the grand jury, San Diego Taxpayers' Association, City and County Boards of Health, Board of Directors of the San Diego Chamber of Commerce, League of Women Voters, and Board of Directors of the Community Welfare Council. The main reasons given for the consolidation recommendation were that duplication would be reduced to a minimum, costs of public health operation would be equalized between city and county taxpayers, and in an emergency, use of full staff would be authorized regardless of city-county borders. After the California Legislature ratifies the necessary charter changes in January, consolidation will go into effect February, 1953.

At the same election a proposal was made for the reconstitution of the county board of health. This proposal was carried by a three to one vote. The composition of the new county board of health of seven members will be: one member designated by the San Diego City Council to act as their representative, one member designated by the Board of Supervisors of San Diego County to act as their representative, and five additional members to be appointed by the board of supervisors in the following manner: one to be chosen from a list of three nominees presented jointly by the incorporated cities of the county, excluding the City of San Diego; two members to be appointed from a list of not more than five nominees submitted by the San Diego County Medical Society; two members representing the citizens at large, one a resident of the unincorporated area of the county and the other a resident of the incorporated area. No single professional or business group shall constitute a majority of the membership. The members of the county board of health shall serve without compensation and their duties will be mainly advisory.

Mosquito Abatement and Agriculture Discussed at Conference

State members of the Bureau of Vector Control, State Department of Public Health, assisted in the planning and conduct of a significant conference held for local mosquito abatement personnel at the Davis Campus of the University of California on October 29th and 30th. The subject of the conference was the relationships of agriculture and mosquito abatement. It was arranged to promote closer cooperation and bring about greater understanding between local

(Continued on page 80)

Mosquito Abatement

(Continued from page 79)

farm advisers' offices and mosquito control agencies within areas of their mutual interest.

Specialists in agriculture from the University of California College of Agriculture and the Agricultural Extension Service presented discussions on agricultural trends, soils, irrigation principles and management of such irrigated crops as pasture, rice and cotton. Richard F. Peters, Chief of the Bureau of Vector Control, and Robert H. Soroker, Assistant Vector Control Specialist with the bureau, contributed to the mosquito abatement phases of the discussion, and Mr. Peters was moderator for an informal question and answer exchange which brought out the conditions in agriculture which support mosquitoes. Further steps in this field of needed agency cooperation are being planned on this subject and in other phases of vector control.

Dr. Kupka Returns From Samoa

Dr. Edward Kupka, Chief of the Bureau of Tuberculosis, State Department of Public Health, returned October 6th from a short-term assignment with the Government of American Samoa. Dr. Kupka left July 17th upon the request of that government for a qualified person who could aid in setting up a tuberculosis control program and facilities for the care of tuberculosis patients. Tuberculosis is a problem there because smallness of the habitable area makes it one of the most densely populated regions of the world.

American Samoa had been under Navy administration from 1899 to 1951 when the Department of the Interior took over and set up the Government of American Samoa. While there Dr. Kupka worked under the direction of Dr. John R. Dean, formerly a Los Angeles surgeon, who became the first medical director after the change of administration.

During his assignment in Samoa Dr. Kupka was able to initiate the reorganization of the tuberculosis clinical services and the setting up of the first formal tuberculosis control program. As control measures hospital admission X-rays and tuberculin testing of nurses and hospital employees were instituted; training courses for native practitioners and nurses were established (native practitioners have had a four-year general medical course at the Suva Medical School); a simple tuberculosis registry was outlined; and a voluntary tuberculosis association organized.

Review of Reported Communicable Disease Morbidity—October, 1952

Diseases With Incidence Exceeding the Five-year Median

Diseases	Oct., 1952	Oct., 1951	Oct., 1950	5-year median
Amebiasis	76	50	37	54
Encephalitis	86	34	49	56
German Measles	298	240	159	219
Hepatitis, infectious	150	22	20	29
Measles	541	456	371	456
Meningitis, meningococcal	24	24	11	19
Mumps	1,665	956	740	954
Pertussis	405	323	218	314
Poliomyelitis	854	666	293	571
Salmonella infections	69	59	20	49
Shigella infections	103	96	65	88
Streptococcal infections, Resp. including Scarlet Fever	366	457	267	364

Diseases Below the Five-year Median

Diseases	Oct., 1952	Oct., 1951	Oct., 1950	5-year median
Diphtheria	2	8	13	7
Rabies, animal	2	3	12	5
Typhoid fever	9	11	7	9

Tuberculosis and the Venereal Diseases

Venereal diseases	Oct., 1952	Oct., 1951	Oct., 1950	5-year median
Syphilis	686	764	754	734
Gonococcal infections	1,663	1,830	1,402	1,632
Chancroid	17	34	36	29
Granuloma inguinale	—	1	2	1
Lymphogranuloma venereum	4	14	9	9
Tuberculosis (all forms)	749	768	693	737

² Median not calculated.

HEMATOLOGY RESEARCH WEEK

The period November 10 to 17, 1952, is being observed throughout the Nation as Hematology Research Week in order to focus attention on the need for greater knowledge of certain diseases of the blood, such as leukemia, Hodgkins disease and the various forms of anemia.

Research in the field of hematology has made possible the control of pernicious anemia and certain other disorders of the blood, but little or no headway has as yet been made in finding controls or cures for some of the other blood diseases.

Our best hope for the solution to the mysteries of these diseases is through intensive research. I urge that the various groups engaged in research activities of this character be given the widest possible public support so that we may soon have a preventive or cure for these dread diseases.

Earl Warren
Governor

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2

5-year
median

20
31
141
20
371
10
900
323
386
20
60
204

year
median

20
17
10
040
530
1
1
1